Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

MEDME SERVICE CORPORATION
PO BOX 920173
EL PASO TX 79902

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number:
M4-10-5136-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The NMES unit was purchased on DOS 10/20/99. Supplies are warranted and payable when a stim unit has been purchased. The carrier paid supplies for DOS 11/21/09 & 12/21/09. The RX is for 6 mos of supplies. Please remit so file can be closed. Rental was preauthorized and paid the supplies included. The patient needed new supplies when purchase was approved. The same unit rented was purchased therefore supplies are not included with purchase. MAR is $37.81 per unit."

Amount in Dispute: $1,058.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: **"**The office has reviewed the dispute packet and documentation submitted by the requestor, MEDME Corporation for dates of service 10/21/09 through 03/22/10. The office will maintain denial for HCPCs code A4595 for 197 – Payment denied/reduced for absence of precertification/preauthorization. The Office would like to note that according to our records, the purchase of the unit took place on 10/20/09 in which the supplies that were to be inclusive with the purchase per Medicare's payment policies did not ship until 10/21/09. The Division adopted Rule §137.100(f) on May 1, 2007 and states 'a health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with rule 134.600 of this title. Review of the ODG for Sprain of the Thoracic spine and Cervical Spine found that the ODG is silent for the use of Neuromuscular

Stimulators for these diagnoses. Although the unit was preauthorized the *medical necessity* for replacement supplies has not been established."

Response Submitted by: State Office of Risk Management, POB 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2009, January 21, 2010, February 21, 2010, March 22, 2010,	HCPCS Code A4595NU	$1058.68	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the procedures for health care providers to obtain preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 23, 2010

- 197 – Payment denied/reduced for absence of precertification/preauthorization.

Explanation of benefits dated May 10, 2010

- 197 – Payment denied/reduced for absence of precertification/preauthorization.
- 193 – Original payment decision is being maintained. This claim was process properly the first time.

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor have preauthorization for the service in dispute?
3. Is the requestor entitled to reimbursement?

Findings

Pursuant to 28 Texas Administrative Code §137.100(f), review of the ODG treatment guidelines for diagnosis 847.2 – Sprain Lumbar region does not recommend the use of a Neuromuscular Electrical Stimulator unless certain criteria is met. The criteria listed is for spinal cord injuries and must meet all the requirements. If the requirements are not met, preauthorization is required. The Requestor did not

seek preauthorization for the supplies in accordance with 28 Texas Administrative Code §134.600(p)(12).

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		September 8, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).